DPHHS-QAD/CCL-025A
(Revised 8/07)

State of Montana
Department of Public Health and Human Services
Quality Assurance Division

FAMILY /GROUP DAY CARE
NEW PROVIDER APPLICATION CHECKLIST

PLEASE ATTACH:

_____ **New Application Form** (must be completed in full, signed, dated, and notarized)

_____ **W-9 Tax ID Form** (Please submit 2 copies)

_____ **Insurance Verification Form** (Must be completed and signed by Insurance Agent)

_____ Current Public Liability Insurance _____ Current Fire Insurance

_____ **Activity Schedule / Written Plan**

_____ **Sample Weekly Menu**

_____ **Floor Plan / Square Footage Report**

_____ **Written Fire / Evacuation Plan (**see the directions on the Fire Safety Record and Evacuation Plan Form)

_____ **Release of Information** (must be completed in full, signed, dated, and notarized)

_____ Yourself _____ Your Spouse _____ Any Additional Workers

_____ Any One Else Living In The House Age 18 or Over

_____ **Statement of Health** (must be completed in full, signed, and dated)

_____ Yourself _____ Your Spouse _____ Any Additional Workers

_____ Any One Else Living in the House Age 18 or Over

_____ **Immunization Records** (MMR-Measles, Mumps, Rubella; Td-Tetanus Diphtheria – See Page 2 of Application)

_____ Yourself _____ Your Spouse _____ Any Additional Workers

_____ Any One Else Living in the House Age 18 or Over

_____ **First Aid Certification** (For Anyone Providing Direct Care To Children)

_____ **Infant, Child, and Adult CPR Certification** (For Anyone Providing Direct Care To Children)

_____ **Out of State Background Checks** (must be fingerprint based)

_____ Yourself _____ Your Spouse _____ Any Additional Workers

_____ Any One Else Living in the House Age 18 or Over

Mail Completed Packet To:
DPHHS/QAD/Child Care Licensing
Attn: Bobbi Jo Walla
2121 Rosebud Dr Ste D
Billings, MT 59102

Phone: (406) 655-7625